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Ongoing priorities and themes and follow-up

Report of the international expert group meeting on the theme "Sexual health and reproductive rights: articles 21, 22 (1), 23 and 24 of the United Nations Declaration on the Rights of Indigenous Peoples"

Summary

The present report provides an overview of the issues discussed at the international expert group meeting on the theme "Sexual health and reproductive rights: articles 21, 22 (1), 23 and 24 of the United Nations Declaration on the Rights of Indigenous Peoples", held from 15 to 17 January 2014 at United Nations Headquarters. It focuses on the conclusions and recommendations of the expert group meeting, which, among other things, called for increased emphasis on the provision of intercultural health care that responds to and engages with indigenous peoples' notions of health and illness, traditional medicinal knowledge and practices, as well as a conceptual framework that links their biological, spiritual and emotional lives.

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I. Introduction

1. At its twelfth session, the Permanent Forum on Indigenous Issues recommended that the Economic and Social Council authorize a three-day international expert group meeting on the theme "Sexual health and reproductive rights: articles 21, 22 (1), 23 and 24 of the United Nations Declaration on the Rights of Indigenous Peoples". On 7 November 2013, at its reconvened substantive session of 2013, the Council, in its decision 2013/259, authorized the international expert group meeting, which included the participation of members of the Permanent Forum, representatives of the United Nations system, other interested intergovernmental organizations, experts from indigenous peoples' organizations, and interested Member States. The Council also requested that the results of the meeting be reported to the Permanent Forum at its thirteenth session, in May 2014. The meeting was organized by the secretariat of the Permanent Forum. The agenda and programme of work are contained in annex I to the present report.

II. Organization of work

A. Attendance

2. The following members of the Permanent Forum attended the meeting:

Mariam Wallet Mohamed Aboubakrine

Maria Eugenia Choque Quispe

Edward John

3. The Special Rapporteur on the rights of indigenous peoples, James Anaya, and the Chair of the Expert Mechanism on the Rights of Indigenous Peoples, Wilton Littlechild, also attended the meeting.

4. The following experts from the seven sociocultural regions participated in the meeting:

Larisa Abryutina (Eastern Europe, Russian Federation, Central Asia and Transcaucasia)

Clive Aspin (Pacific)

Mirna Cunningham (Latin America and the Caribbean)

Jessica Danforth (North America)

Agnes Leina Ntikaampi (Africa)

Tuku Talukder (Asia)

5. The meeting was attended by observers from Member States; United Nations agencies, funds and programmes; other intergovernmental organizations, indigenous peoples' organizations; and non-governmental organizations.

B. Documentation

6. The participants had before them a draft programme of work and documents prepared by the participating experts. The documents for the expert group meeting are set out in annex II to the present report. The documentation is also available on the website of the secretariat of the Permanent Forum on Indigenous Issues (http://undesadspd.org/IndigenousPeoples/EGM2014SexualHealthandReproductiveRights.aspx).

C. Opening of the meeting

7. At the opening of the expert group meeting, the Assistant Secretary-General for Policy Coordination and Inter-Agency Affairs of the Department of Economic and Social Affairs of the Secretariat made a statement welcoming everyone to the meeting. The Chief of the secretariat of the Permanent Forum also welcomed the regional experts and representatives of the United Nations entities and outlined the objectives of the meeting.

D. Election of officers

8. Maria Eugenia Choque Quispe, a member of the Permanent Forum, was elected Chair of the meeting, and Alfonso Barragues, of the United Nations Population Fund (UNFPA), was elected Rapporteur.

E. Conclusions and recommendations

9. On 17 January 2014, the experts adopted by consensus the conclusions and recommendations contained in section IV below.

III. Highlights of the discussion

10. Right from the outset, some experts observed that the language related to the theme of the meeting, "Sexual health and reproductive rights" had evolved over the past 20 years. The International Conference on Population and Development, held in Cairo in 1994, and the Fourth World Conference on Women, held in Beijing in 1995, refer to a constellation of rights in existing human rights instruments which rest on the recognition of the rights of couples and individuals to control their sexuality and make reproductive decisions free of discrimination, coercion and violence while enjoying the right to the highest attainable standard of sexual and reproductive health. As the international community approaches 20 years of implementation of the Cairo and Beijing agendas, the term "sexual and reproductive health and rights" has emerged strongly in the context of the ongoing International Conference on Population and Development beyond 2014 international review. United Nations treaty monitoring bodies also consistently refer to the term "sexual and reproductive rights" in their work and jurisprudence.

11. Experts noted that, over the past 20 years, the world had experienced remarkable progress in important areas of sexual and reproductive health and rights:

maternal mortality had been significantly reduced; access to voluntary family planning and modern methods of contraception had increased; and access to treatment, where available, had transformed HIV and AIDS into a manageable disease. However, available data show that indigenous peoples are still disproportionately affected by many of these and other problems and little change has effectively occurred in their lives and well-being.

12. While the scarcity of data does not provide a real picture of the magnitude of these problems, participants emphasized that many countries had yet to legally recognize the identity and status of indigenous peoples. As a result, indigenous peoples become invisible or subsumed under such generic categorizations as ethnic minorities or impoverished and marginalized communities, without recognition of their distinct cultural identity and traditional governance systems. Even where identity and status are recognized, data disaggregated by indigenous status are often not available, making policies and programmes difficult to design and evaluate. The absence of civil registration was mentioned as a major impediment to ensuring access to basic social services and the ability to claim rights. Civil registration systems often do not reach indigenous peoples living in rural and remote locations, or, if they do, they are not sensitive to the culture of indigenous peoples, as shown for instance by the refusal to register children under indigenous names, which possibly inhibits parents from using these services.

13. Despite the normative requirement in international human rights law that health services be available, accessible, acceptable and of quality, indigenous peoples are particularly affected by issues of access owing to geographic, cultural, linguistic and political barriers, as well as indirect costs, such as transportation and user fees. The case of indigenous women being discharged from hospitals on the same day they deliver a baby for not having money for fees was cited by participants. Where sexual and reproductive health services are available, there is an obvious lack of skilled health workers, with dilapidated or ill-equipped structures. Moreover, discriminatory attitudes by service providers deter indigenous peoples from accessing these services. Although progress in the design of culturally acceptable maternal health services in certain Latin American countries was noted, there is still room for improvement, with other regions lagging behind.

14. Indigenous women and girls frequently face multiple forms of discrimination based on their indigenous status, age, location, economic status, sexual orientation and gender identity, marital status and disability. The feminization of the HIV pandemic in some countries and its associated stigma and discrimination was another compounding factor noted during the meeting. Intersecting discrimination entails that different groups and individuals within indigenous communities may face different barriers requiring specific responses from both the State and indigenous institutions and authorities.

15. Structural determinants, such as the ongoing effects of the colonization, occupation and militarization of indigenous peoples' territories, and the persistence of hegemonic views that continue to regard indigenous cultures as inferior, were also cited to explain the gaps between indigenous peoples and the non-indigenous population in the realization of sexual and reproductive health and rights.

16. The impact that development models based on the extraction of natural resources have on the health, safety and lives of indigenous peoples was repeatedly discussed during the meeting, with specific reference to the impact of pollution

caused by extractive industries on the sexual and reproductive health of indigenous peoples. In these contexts, women in particular are more vulnerable to HIV and sexual violence owing to the influx of male workers in indigenous peoples' territories, with subsequent reported cases of rape, assault and trafficking for sexual exploitation.

17. In the complex web of causal interconnections affecting the sexual and reproductive health and rights of indigenous peoples, the United Nations Declaration on the Rights of Indigenous Peoples provides a comprehensive framework for addressing the gaps identified by participants. The right to self-determination, the right to maintain and develop their own systems or institutions, the right to traditional medicines and health practices and the principle of free, prior and informed consent are cornerstones for the achievement of sexual and reproductive health and rights for indigenous peoples. Moreover, the obligations of States to improve the situation of indigenous peoples, including their right to education, health, food, water and sanitation, the freedom from violence and discrimination, and their right to decent work, were found to be mutually reinforcing and interdependent. International Labour Organization (ILO) Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries was cited as another fundamental instrument to address these and other underlying determinants of sexual and reproductive health, but still requires effective implementation.

18. Participants pointed out that a main challenge was constituted by the lack of political will to implement the Declaration and to redefine the status quo of power imbalances which, exacerbated by prevailing economic development models, pushes entire indigenous communities to marginalization and exclusion.

Intercultural health

19. The demand for culturally appropriate sexual and reproductive health services has been on the agenda for indigenous peoples, in particular indigenous women, for more than two decades. The International Conference on Population and Development reflected this demand by recognizing respect for cultural diversity, the need to ensure respect for the rights of indigenous peoples in a holistic way and the need to ensure their active and meaningful participation.

20. Intercultural sexual and reproductive health promotes physical, emotional, spiritual, individual and community well-being in all aspects of human sexuality and reproduction in ways consistent with the human dignity and rights of both men and women. Intercultural health implies and requires the development and incorporation of health models and best practices that integrate indigenous and Western medicine. These processes must be based on mutual respect, the recognition of traditional knowledge, the willingness to engage in a democratic process of exchange and the commitment to move towards an integrated health system.

21. The United Nations Declaration provides a framework for the recognition of indigenous peoples' rights to both modern and traditional health systems, comprising access to health information, medicines and services, as well as the recognition and development of health systems for indigenous peoples. The application of the principle of free, prior and informed consent through participatory mechanisms and procedures is fundamental in designing and implementing intercultural health policies that ensure access to quality and culturally appropriate sexual and reproductive health services. The Declaration establishes the right of

indigenous peoples to promote, develop and maintain their own institutions, which entails that States adopt measures to guarantee the collective rights of indigenous peoples to attain their right to health through their own systems, ancestral knowledge and health practices.

22. Over the past 20 years, culturally sensitive health policies and models have been developed in some countries, resulting in health systems that are more responsive to the culture and needs of indigenous peoples, and with greater representation of indigenous women.

23. For instance, there have been some fundamental legislative and policy advances, in Latin America in particular, as well as improvements to institutional frameworks. Some Constitutions explicitly recognize the identity and systems of indigenous peoples and the intercultural nature of the State, such as in Bolivia (Plurinational State of) and Ecuador. In 17 countries in the region, there are government entities responsible for intercultural health. Public policies have also been developed in different social sectors by using a cultural lens and promoting some form of indigenous participation in their design.

24. Participants shared the experience developed in some countries of the Andean region, where innovative strides have been taken to develop intercultural health models, predominantly in the area of maternal health. On the basis of strategic partnerships between the Continental Network of Indigenous Women of the Americas, the Indigenous Fund, the Andean Health Organization and UNFPA at both the regional level and nationally in Bolivia (Plurinational State of), Ecuador, Guatemala and Peru, initiatives were focused on strengthening the capacity of indigenous women's networks to conduct advocacy for the provision of quality and culturally acceptable maternal and reproductive health services. Programmes have contributed to legal reforms and the adoption of public policies and protocols on intercultural reproductive health; the recognition of the role of traditional birth attendants within the official health system; the generation of knowledge and of methodological and advocacy tools; and the increase in indigenous women's access to reproductive health services in selected regions. Building on these national experiences, the Commission on Intercultural Health of the Andean Health Organization is in the process of discussing the adoption of subregional basic standards on intercultural health to define objective and measurable requirements necessary in order to provide and monitor quality and acceptable intercultural maternal health services.

25. Participants drew some lessons from the above-mentioned case, as well as from other experiences reflected in the background documentation for the meeting, as follows:

(a) Culturally appropriate interventions cannot be designed in a vertical and top-down fashion. They require participatory processes for dialogue, consensus building and community ownership. Despite progress in setting standards, in many places programme implementation has not occurred with the effective participation of indigenous women;

(b) Health system monitoring frameworks still need to adequately capture the integrality of traditional health systems by developing indicators that reflect the complexity of intercultural health at all levels of the State administration and in its articulation at the community level. In that regard, the measurement of the

application of intercultural health standards has been easier at the local level with regard to service delivery points;

(c) Adopting laws is an important step in the process towards achieving intercultural health. However, changing the attitudes of health professionals and medical staff is a long undertaking requiring the integration of intercultural approaches in the school curriculum starting from basic to higher education, including technical health education. The need to develop incentives to encourage this learning process was also highlighted;

(d) National policies and programmes require government and donor support on a long-term basis. Unfortunately, the approach to intercultural health by donors has been limited to the support of legal and policy reform processes and the formulation of standards, on the assumption that indigenous communities can then take this work forward on their own. Unless structural factors of inequality and discrimination are addressed, indigenous peoples will remain in a disenfranchised position without the resources or technical assistance to succeed on their own;

(e) The promotion of intercultural health models has narrowly focused on maternal health. An intercultural lens should be equally relevant in other components of sexual and reproductive health, such as family planning, addressing teenage pregnancy, HIV prevention, treatment and care, and gender-based violence prevention and response.

26. While the notion of "cultural sensitivity" has been more in vogue in the policy arena in recent years, United Nations treaty bodies have consistently referred to "cultural acceptability" as one of the key components of the right to health. Cultural acceptability guides the design of services and promotes the active participation of indigenous peoples so that services are respectful of their cultures and found to be appropriate by their intended users. Cultural acceptability is not only a normative requirement but also an evolving concept that can benefit from the experience of indigenous peoples to help United Nations treaty bodies to further define its meaning and practical implications.

27. In the light of the above, some participants presented the concept of "cultural safety" as a minimum standard that goes beyond more conventional understandings of "cultural sensitivity". This concept analyses issues of power imbalances, institutional discrimination, colonization and relationships with hegemonic cultures and health systems of former colonizers with a view to ensuring that individuals and families feel safe in their bodies, lands and territories, but also in urban settings where indigenous peoples live and work. Cultural safety focuses on the understanding of "self" as a cultural bearer and the development of relationships that engender trust and respect. This means that the experience of colonialism, assimilation and genocide must be factored into the relationship between client or patient and service providers.

Maternal health and family planning

28. Participants shared their experiences and country evidence on access by indigenous peoples, in particular indigenous women, to family planning and maternal health services. In presentations by experts from Bangladesh and the Russian Federation, as well as experiences from other countries, geographic and economic issues were identified as key barriers preventing indigenous peoples from

accessing these services. In the case of the Russian Federation, the former Soviet Government implemented mobile clinics to reach out to indigenous peoples. While this model greatly contributed to improving the health conditions of indigenous women, girls and children, since the end of the Soviet era these clinics have been gradually dismantled as a result of shrinking financial flows. This experience underscores the need to sustain development efforts both by Governments and international development agencies. Unfortunately, as in Latin America, international development agencies are gradually scaling down their cooperation efforts in middle-income countries despite ongoing inequality gaps dramatically affecting the lives and well-being of indigenous peoples.

29. In the case of Bangladesh, it was noted that the discrimination faced by women and girls, particularly from rural areas, due to their sex and exacerbated by poverty was among the main factors explaining poor health outcomes. While current national health policy recognizes the need for special programmes for indigenous peoples living in remote locations, these newly designed programmes have not reached target communities and approaches have been predominantly top-down, without the involvement of indigenous women and girls in the inception process.

30. Access to accurate and relevant information is fundamental to both family planning and maternal care. How to communicate with indigenous communities and youth poses particular challenges. Experience shows that increased access to information on health care and contraception has not resulted in marked behavioural changes. Both messaging and transmission of information should be reviewed from an intercultural lens, including the use of local indigenous languages in accessible formats. Without effective communication of information, indigenous women will continue to be at risk of involuntary sterilization and will be limited in their ability to make sexual and reproductive choices.

HIV and AIDS

31. Experts noted that HIV had been a serious concern among indigenous peoples for many years. Despite a general perception that indigenous communities are at a lower risk because they live in remote areas and their communities are more cohesive, where data are available indigenous peoples are disproportionately affected by HIV. Therefore, experts stressed that, despite the lack of disaggregated data in many countries, it was safe to conclude that HIV is a serious problem affecting indigenous peoples, as it comes associated with stigma, discrimination, lack of sexuality education, lack of contraception and high levels of sexual violence, alcoholism and drug use, all of which are factors disproportionately affecting indigenous peoples. Thus, the lack of data should not be an excuse for inaction. More effort should be placed on preventive measures targeting indigenous peoples. However, indigenous peoples tend to be forgotten in global and national responses to the pandemic.

32. Participants referred to existing evidence that indigenous peoples affected by HIV have a long and enduring history of mistrust of health services, which results in poor access to health care, late testing for HIV and poor or no care and support for people living with HIV. Conversely, indigenous peoples are part of familial and cultural networks which need to be taken into consideration in the design and development of indigenous HIV prevention programmes.

33. Participants noted that people of all ages, from youth to elders, need to be involved in campaigns to prevent the transmission of HIV in indigenous communities. Indigenous peoples and communities need to have access to supportive education and testing environments which recognize and respect indigenous cultural values.

34. In response to high rates of HIV among indigenous peoples, a number of community-based initiatives have been developed which provide a viable and realistic alternative to non-indigenous-led initiatives to prevent the transmission of HIV among diverse indigenous peoples. Likewise, at the international level, a durable and sustainable global network of indigenous peoples and communities has been established to raise awareness of HIV and its impact on indigenous peoples.

35. Some experts presented a few global and national community initiatives providing clear evidence that, after three decades of HIV, indigenous communities are taking charge of strategies to prevent the ongoing transmission of HIV among indigenous peoples and to provide care and support for those living with HIV. For indigenous peoples, the international networks that have come together in response to HIV are fundamental to overcoming the challenges posed by HIV, such as the International Indigenous Working Group on HIV and AIDS, which was created soon after the adoption of the Toronto Charter: Indigenous Peoples' Action Plan on HIV and AIDS at the sixteenth International AIDS Conference, held in 2006.

36. These networks must be supported nationally and internationally to ensure the effectiveness of their work to overcome HIV and to ensure the realization of self-determination and the ongoing viability of indigenous peoples' communities for generations to come. The need to open up to partnerships with the private sector was deemed strategic in view of the current economic and aid environment. One example was shared from Chile, where the transport sector, which traditionally employs many indigenous workers, is working in partnership with indigenous communities to raise awareness on HIV prevention, voluntary testing and treatment.

Sexuality, taboos and education

37. Participants highlighted that sexuality was still a taboo subject among many indigenous communities across the globe. While in some cases the fact of "not talking about sex" with children and grandchildren may be perceived as inherent to the culture and traditions of indigenous peoples, in numerous other cases this silence results from the ideological and religious views that were imposed on them in the context of colonialism. Despite these processes, participants noted that many indigenous communities preserve traditional coming-of-age ceremonies and rites of passage, through which indigenous adolescents come to understand not only their identity but also what it means to take on adult responsibilities within themselves, their bodies and their communities.

38. Sexual education was identified at the meeting as a fundamental right to which everybody should be entitled and as a concrete intervention to build the knowledge and skills of indigenous adolescents and youth to be able to deal with their bodies and sexuality in safe and responsible ways. Furthermore, sexuality education should also target parents and grandparents to build their capacities for intergenerational dialogues on these issues. However, the general view was that, where available, sexuality education seldom promotes an integral view of sexuality and gender relations beyond basic biological aspects and the prevention of teenage pregnancy. It

was also noted that sexuality education is not specific to indigenous communities in its design, nor is it transmitted in ways that will help indigenous adolescents and youth to develop and apply their knowledge.

39. The lack of access to accurate and culturally safe sexuality education has a direct impact on unwanted pregnancies among teenage indigenous girls, compounded by increased levels of sexual violence and alcohol abuse, underscoring the need to ensure access to emergency contraception in ways that respect the right to privacy. Integral approaches emphasize the focus on education and school retention, as well as the development of critical bargaining skills and self-esteem, as opposed to more conventional prevention approaches that focus on blaming girls for being pregnant or scaring them over the negative consequences of teenage pregnancy.

40. Furthermore, there was a call for culturally appropriate sexuality education which integrates broader notions of gender equality, human rights and sexual and reproductive health and rights and respect for diverse sexual orientations and gender identities, including lesbians, gays, bisexuals, transgender, queer, questioning, asexual, intersex, two-spirited and other identities. There was also a call for the inclusion of indigenous adolescents and youth in the design of culturally safe sexuality education curriculums and in the development and expansion of youth peer education. In addition, participants noted the need to invest in intergenerational spaces of analysis and reflection where older women can share views and experiences about marriage and sexuality and the revival of coming-of-age ceremonies and rites of passage.

Harmful practices (female genital mutilation/cutting)

41. Notwithstanding the fundamental claim of indigenous peoples to respect and value their cultures, all experts unanimously acknowledged that not all cultural traditions are intrinsically beneficial. From that standpoint, culture should not be understood as a static or monolithic concept. In the same way that different population groups can have different interpretations of local cultures, these interpretations are in constant evolution and change. Ultimately, culture and tradition should not be invoked as a justification to violate the rights of an individual or a specific population group, whether women, children, indigenous persons living with HIV or others.

42. One practice examined at the meeting was the persistence of female genital mutilation/cutting among indigenous communities, predominantly in Africa and elsewhere. It was noted that the practice of cutting the genitalia of women during childhood or adolescence does not have medical reasons; it responds to gender constructs regarding the expected role of women in life and is a requirement for girls to transition from childhood to adulthood and marriageability.

43. Experts discussed four approaches that have been used to address female genital mutilation/cutting since it was placed at the top of the international human rights and development agenda at the International Conference on Population and Development in Cairo in 1994, namely the cultural/moral, health, social and legal approaches. In view of this persisting practice, participants underlined the importance of assessing what has and has not worked with each of these approaches while drawing lessons from those few places and experiences which have managed to eradicate the practice.

44. Participants concluded that all four approaches would probably be the most sensible way forward. While there was clear understanding that the rights of women and girls should always be respected and protected, participants noted that strategies to address harmful practices will succeed in changing behaviours only if a cultural lens is used so that change is promoted from within and owned by the community. Participants identified access to formal education as a long-term emancipator of indigenous women from female genital mutilation/cutting, while also emphasizing the need for culturally appropriate education and the participation of indigenous peoples in its design so that education is a vehicle for empowerment and not for cultural alienation.

Participation and accountability

45. Participation was a recurrent topic during the discussion. The need to include indigenous peoples in research, data collection and policy/programme design, monitoring and evaluation was underscored.

46. Similarly, the incorporation of indigenous women into both State-led and customary indigenous justice systems was found to be a critical way to ensure that more attention is given to the protection of sexual and reproductive health and rights, such as in cases of forced sterilization, sexual violence and discrimination within health systems.

47. Participants concluded that protecting and addressing the health of indigenous peoples requires a framework of sexual and reproductive justice that effectively works towards addressing issues of systemic racism, colonization, violation of land rights, language discrimination, incarceration and other related human rights violations.

IV. Conclusions and recommendations

48. The Permanent Forum should include in its discussions on the right to health the issue of sexual and reproductive health and rights. It should ensure the consistent use of language — either "sexual and reproductive health and rights" or "sexual and reproductive rights" — in accordance with United Nations treaty monitoring bodies and the outcomes of the International Conference on Population and Development beyond 2014 review, including the Bali Global Youth Forum Declaration, the Montevideo Consensus on Population and Development and the report of the International Conference on Human Rights.

49. States must take legal, policy, budgetary and other special positive measures to address sexual and reproductive inequalities by tackling the structural causes of those inequalities, which include the legacy of colonization and violence, and the intersectional discrimination that indigenous women and girls face owing to their ethnicity and gender. National and subnational protection mechanisms with a mandate to address discrimination against indigenous peoples should be strengthened with a view to prioritizing and addressing intersecting discrimination in the context of sexual and reproductive rights.

50. States must ensure a legal environment that enables indigenous women and girls to exercise their sexual and reproductive rights. This includes reviewing national laws and policies to ensure that they are in compliance with international

human rights law, removing barriers to accessing sexual and reproductive information and services, and ending the criminalization of reproductive health-care services and consensual sexual conduct. Furthermore, States must ensure that indigenous women and girls have meaningful access to effective legal remedies if their sexual and reproductive rights are violated.

Participation

51. States must respect the full and effective participation of indigenous peoples in the formulation, implementation, monitoring and evaluation of sexual and reproductive health and education policies and programmes, as well as in the development of laws and standards relevant to indigenous children, adolescents and youth. Information on laws, policies and budgets related to sexual and reproductive rights and health must be made available to indigenous peoples in a transparent and timely manner and in accessible formats, including in their own languages. Indigenous organizations participating in the above-mentioned legal and policy processes must include the voices and perspectives of indigenous women, girls, men and boys, traditional leaders, traditional healers and midwives, persons of diverse gender identities and sexual orientations, sex workers, indigenous persons with disabilities and those living with HIV/AIDS.

52. Indigenous peoples should engage in multisectoral and cross-disciplinary dialogues with policymakers, economists, academics, women's advocacy groups, health practitioners and other relevant stakeholders to promote positive changes in laws, policies and practices pertaining to sexual and reproductive health and rights. In this regard, they should especially collaborate with both indigenous and non-indigenous parliamentarians in the drafting of laws and the oversight of public policies and budgets, advocating in particular for the adoption of culturally appropriate laws.

53. States and UNFPA should promote the rights of indigenous youth at the regional and national levels, including through their participation in the process leading to the design and implementation of the International Conference on Population and Development beyond 2014, and, to the extent possible, ensure their participation in discussions led by UNFPA on the post-2015 development agenda.

54. The Permanent Forum on Indigenous Issues, the Expert Mechanism on the Rights of Indigenous Peoples and the Special Rapporteur on the rights of indigenous peoples should continue to support the voices, views and recommendations of indigenous people living with disabilities in political and policy processes affecting their sexual and reproductive health.

Intercultural health

55. States and United Nations entities should secure and increase resources for intercultural health services in indigenous communities in accordance with the right to self-determination of indigenous peoples, as well as quality of care standards that are culturally appropriate, incorporating the standard of "cultural safety".

56. States should adopt measures to recognize, respect and strengthen indigenous traditional health systems (traditional midwives, healers) and, in collaboration with these systems, design a comprehensive and intercultural package of sexual and reproductive health services, including contraception, maternal care, safe abortion

and post-abortion services, spiritual support, traditional healing, aseptic techniques, HIV prevention and treatment, appropriate referral systems between indigenous and national health systems, and any other services as indicated in paragraph 7.6 of the Programme of Action of the International Conference on Population and Development.

57. Successful programmes on intercultural health models, some of which are in place in South and Central America and the Caribbean, should be assessed and eventually scaled up and expanded to other regions, including through South-South and indigenous-to-indigenous cooperation, such as international networks of indigenous women and indigenous youth, communities of practice, and platforms for intergenerational knowledge-sharing.

58. States should establish innovative, intercultural and integral models to improve general access to health care for indigenous peoples, particularly women and girls, who are nomadic or live in remote locations, such as through the development of a network of integrated and permanently operating mobile clinics for primary health care and the application of the "doctor to patient" principle. United Nations entities and other development cooperation actors are urged to develop national and subnational capacities, provide technical assistance and allocate specific resources to implement programmes managed by indigenous women and programmes that provide access to intercultural services and education for their sexual and reproductive health and safe motherhood as a human right.

59. In order to ensure equal health outcomes for indigenous peoples, States must ensure that sexual and reproductive health information and services are available, accessible, acceptable and of high quality. This means that information and services are adequate in number, easily accessible and in close proximity to indigenous areas. They must also be provided free of charge or at a low cost, in languages that indigenous women understand, and on the basis of free, prior and informed consent. Sexual and reproductive health services (or service providers) should also fully respect and incorporate the views of indigenous women and girls concerning their sexual and reproductive health and rights.

60. In close cooperation with indigenous peoples, States and academic institutions, including universities, should provide training and capacity-building for public health officials and health-care workers at all levels to understand and respect indigenous health systems (midwives, healers and other knowledge bearers) and indigenous medicines, as well as to collaborate in building and supporting intercultural health systems.

Education

61. States must develop, in close cooperation with indigenous youth, education programmes on human rights, sexual and reproductive health and rights, gender equality, sexuality education and life skills and ensure that such education is provided to indigenous children and youth in both formal and informal settings. It is recommended that States and United Nations entities support and provide resources for indigenous-specific sexuality education that is culturally safe. The Permanent Forum should conduct a study on the linkages of sexuality education with the restoration of rites of passage and coming-of-age ceremonies. Furthermore, it is recommended that States, United Nations entities and indigenous communities support opportunities for indigenous youth peer education and mentorship in

relation to sexuality and relationships, as well as cultural teachings that are empowering, knowledge-based and free of stigma or judgement.

Interconnections

62. Considering their impact on the sexual and reproductive health and rights of indigenous peoples, we call for a legal review of United Nations chemical conventions, in particular the Rotterdam Convention, to ensure that they are in conformity with international human rights standards, including the United Nations Declaration on the Rights of Indigenous Peoples and the Convention on the Rights of Persons with Disabilities.

63. States must halt the export and import of banned and unregistered pesticides from countries that prohibit their use in their own country as a case of environmental racism and environmental violence with proven and devastating impacts on reproductive and sexual health, in particular maternal and child health.

64. Relevant United Nations entities should conduct a study, in partnership with indigenous peoples' organizations, that documents the linkage between environmental violence, including the operations of extractive industries, chemical pollution and the destruction of the indigenous habitat, and the sexual and reproductive health of indigenous peoples, as well as issues pertaining to sexual exploitation, trafficking of indigenous girls and sexual violence, with concrete recommendations on protection measures.

Gender-based violence

65. States should recognize different gender identities and sexual orientations within indigenous communities and acknowledge that these identities are old and sacred in the world view of many indigenous nations and communities. States should take measures to prevent and protect against discrimination and violence of indigenous lesbians, gays, transgender, two-spirited, queer, questioning, asexual, intersex and gender non-conforming youth and peoples. It is also recommended that United Nations treaty monitoring bodies, including the Human Rights Committee and the Committee on the Elimination of Discrimination against Women, urge States to comply with their international human rights obligation of equality and non-discrimination and to support the efforts of indigenous peoples to address gender-based discrimination and violence from a broad understanding of gender diversity.

66. States, United Nations entities and non-governmental organizations should support the meaningful and effective participation of indigenous peoples, in particular those involved in sex work and street economies, in policies, programmes and other measures to address the impact of heightened violence, stigma, discrimination, criminalization and HIV.

67. States and United Nations entities should promote the active participation of representatives of indigenous peoples, including indigenous women and youth, at the forty-seventh session of the Commission on Population and Development, which will review the implementation of the Programme of Action of the International Conference on Population and Development. The agreed conclusions of the Commission should be discussed at the thirteenth session of the Permanent Forum on Indigenous Issues, with a focus on those pertaining to indigenous peoples' rights,

including their sexual and reproductive rights, as reflected in the Montevideo Consensus on Population and Development and other outcomes of the International Conference on Population and Development beyond 2014 review process.

68. It is recommended that United Nations country teams strengthen and integrate the rights of indigenous women and youth in developing strategies and national and subsectoral plans, particularly, but not exclusively, in the areas of sexual and reproductive health and rights, maternal mortality and morbidity, as well as in policies and plans aimed at adolescents and young people.

Data collection and disaggregation

69. The Permanent Forum should co-host a meeting with organizers of demographic and health surveys, other national health statistical units and experts in the sexual and reproductive health of indigenous peoples to share experiences and advance the development and implementation of guidelines for including indigenous peoples in demographic and health surveys and administrative data systems.

70. The Permanent Forum should coordinate with the World Health Organization, UNFPA and other relevant entities in the formulation of key intercultural standards and indicators of quality of care to be considered in the definition of a future post-2015 goal on universal health coverage that includes the sexual and reproductive health of indigenous peoples.

71. States should ensure universal civil registration that is consistent with the cultural views and choices of indigenous peoples and take specific measures to cover those living in remote locations. Health systems should have the financial and technical means to ensure a continuous process of collecting and updating administrative data on indigenous peoples, including indicators on intercultural health, to be able to monitor what is done in the area of sexual health and reproductive rights. Furthermore, they should ensure the participation of indigenous peoples and organizations in the design of surveys relating to health, while census and survey officials should be trained on how to engage with indigenous peoples in culturally appropriate ways.

72. The Permanent Forum should coordinate with other agencies and actors on the development and implementation of an international research project on the sexual and reproductive health of indigenous peoples, ensuring an active partnership with indigenous peoples and organizations in all stages of the project. Such research would cover all areas included in the present report.

73. The participants commend the indigenous women who participated in the World Conference of Indigenous Women, held in Lima in 2013, support the recommendations that were made regarding sexual and reproductive health and recommend that States support the plan of action developed at the Conference.

74. States should incorporate the agreements on indigenous peoples in the outcome of the Montevideo Consensus on Population and Development and the post-2015 development agenda. More specifically, States should:

(a) Allocate specific resources for the implementation of programmes carried out by indigenous women, especially in rural and remote areas, to ensure access to public services and intercultural education that can guarantee their sexual and reproductive health and safe maternity as a human right;

(b) Acknowledge the strong impact of violence in its multiple manifestations on the integral health of indigenous women, including the impact of environmental contamination, extractive industries, mining, the use of pesticides and toxic substances;

(c) Implement actions with the participation and the consent of indigenous women to prevent and eliminate violence.

75. States and United Nations entities should include the situation of urban indigenous women living in cross-border areas in the design and delivery of sexual and reproductive health services, ensuring their participation and raising awareness of their problems, such as violence and human, drug and weapons trafficking.

HIV and AIDS

76. The Joint United Nations Programme on HIV/AIDS (UNAIDS), international non-governmental organizations and other relevant stakeholders should ensure that indigenous peoples living with HIV are meaningfully engaged in programmes in ways that acknowledge the diverse skills, experiences and expertise they bring to programme development and delivery in accordance with the policy of greater involvement of people living with HIV and AIDS. They should also ensure that indigenous peoples and communities are involved in all aspects of HIV policy and programming in ways that acknowledge and respect the rights and needs of indigenous peoples.

77. United Nations agencies, including UNAIDS and UNFPA, should work together with the Permanent Forum to support and promote international indigenous HIV networks, provide adequate resources to ensure the growth and sustainability of international indigenous HIV networks and collaborations and build the capacity of indigenous peoples and communities by increasing the participation of indigenous peoples in international HIV networks.

78. UNAIDS should ensure the recognition of indigenous peoples as a particular population group with heightened vulnerability to HIV so that specific mechanisms, strategies and resources are allocated to indigenous communities and indigenous-led initiatives in the response to HIV.

79. States should implement best practice HIV models and programmes in indigenous communities and ensure that they are delivered in a way that is respectful of the rights and needs of indigenous peoples.

Harmful practices

80. Relevant United Nations agencies should review what works and what does not work when combating female genital mutilation, in order to ensure an integrated use of the four frameworks (public health, human rights, social and cultural) to eradicate female genital mutilation. A thorough documentation of best practices and lessons learned in eradicating female genital mutilation is recommended.

81. Formal education is a long-term emancipator of indigenous women from female genital mutilation. Therefore, States, United Nations agencies and other international cooperation actors must provide continued support for the education of indigenous girls at all levels by coordinating with local authorities and traditional indigenous leaders and women's organizations to include intercultural sexuality

education, gender equality and human rights in schools in local languages and by supporting community-driven initiatives that empower women and girls with information, knowledge and life skills for the prevention of female genital mutilation and child, early and forced marriages.

Humanitarian affairs

82. United Nations agencies with a mandate on humanitarian affairs, particularly the United Nations High Commissioner for Refugees, the Office for the Coordination of Humanitarian Affairs of the Secretariat and the United Nations Children's Fund should make available for indigenous peoples, especially women, girls and youth, who are refugees or live in a situation of humanitarian crisis, health services, in particular relating to sexual and reproductive health and rights, including through health workers who speak their languages.

83. The United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) should, in close collaboration with other United Nations agencies, help to build the capacity of indigenous women living in conflict-affected areas and in situations of humanitarian crisis, in particular for women-headed households.

84. United Nations entities that have a mandate to defend human rights should, in collaboration with indigenous peoples living in situations of conflict and humanitarian crisis, put in place early warning mechanisms to prevent sexual violence, in particular against indigenous women and girls.

Annex I

Agenda and programme of work

Date time	*Item programme*	
Wednesday, 15 January 2014		
10-10.30 a.m.		Opening of the workshop by the Assistant Secretary-General for Policy Coordination and Inter-Agency Affairs
	Item 1	Election of the Chair and the Rapporteur
10.30 a.m.-1 p.m.	Item 3	Intercultural approach to sexual and reproductive health: access and quality
		Presentation: Mirna Cunningham
3-6 p.m.	Item 4	Harmful practices, gender equality, discrimination and violence
		Presentation: Agnes Leina Ntikaampi
Thursday, 16 January 2014		
10 a.m.-1 p.m.	Item 5	Maternal health and family planning
	Item 6	HIV/AIDS and sexually transmitted infections
		Presentations:
		Larisa Abryutina Tuku Talukder Clive Aspin
3-6 p.m.	Item 7	Sexuality, culture taboos and education
		Presentation: Jessica Danforth
Friday, 17 January 2014		
10 a.m.-1 p.m.	Item 8	United Nations system:
		– World Conference on Indigenous Peoples (September 2014)
		– International Conference on Population and Development beyond 2014 (September 2014)
		– Post-2015 development agenda

Date time	*Item programme*	
		Presentations:
		Secretariat of the Permanent Forum on Indigenous Issues
		United Nations Population Fund
3-6 p.m.	Item 9	Adoption of the conclusions and recommendations

Annex II

List of documents[a]

Concept note for the international expert group meeting on the theme "Sexual health and reproductive rights: articles 21, 22 (1), 23 and 24 of the United Nations Declaration on the Rights of Indigenous Peoples"

Programme of work for the international expert group meeting on the theme "Sexual health and reproductive rights: articles 21, 22 (1), 23 and 24 of the United Nations Declaration on the Rights of Indigenous Peoples"

Paper submitted by Larisa Abryutina

Paper submitted by Clive Aspin

Paper submitted by Jessica Danforth

Paper submitted by Mirna Cunningham

Paper submitted by Agnes Leina Ntikaampi

Paper submitted by Tuku Talukder

[a] All the reports and other documents submitted during the meeting can be found on the website of the secretariat of the Permanent Forum on Indigenous Issues (http://undesadspd.org/IndigenousPeoples/EGM2014SexualHealthandReproductiveRights.aspx).